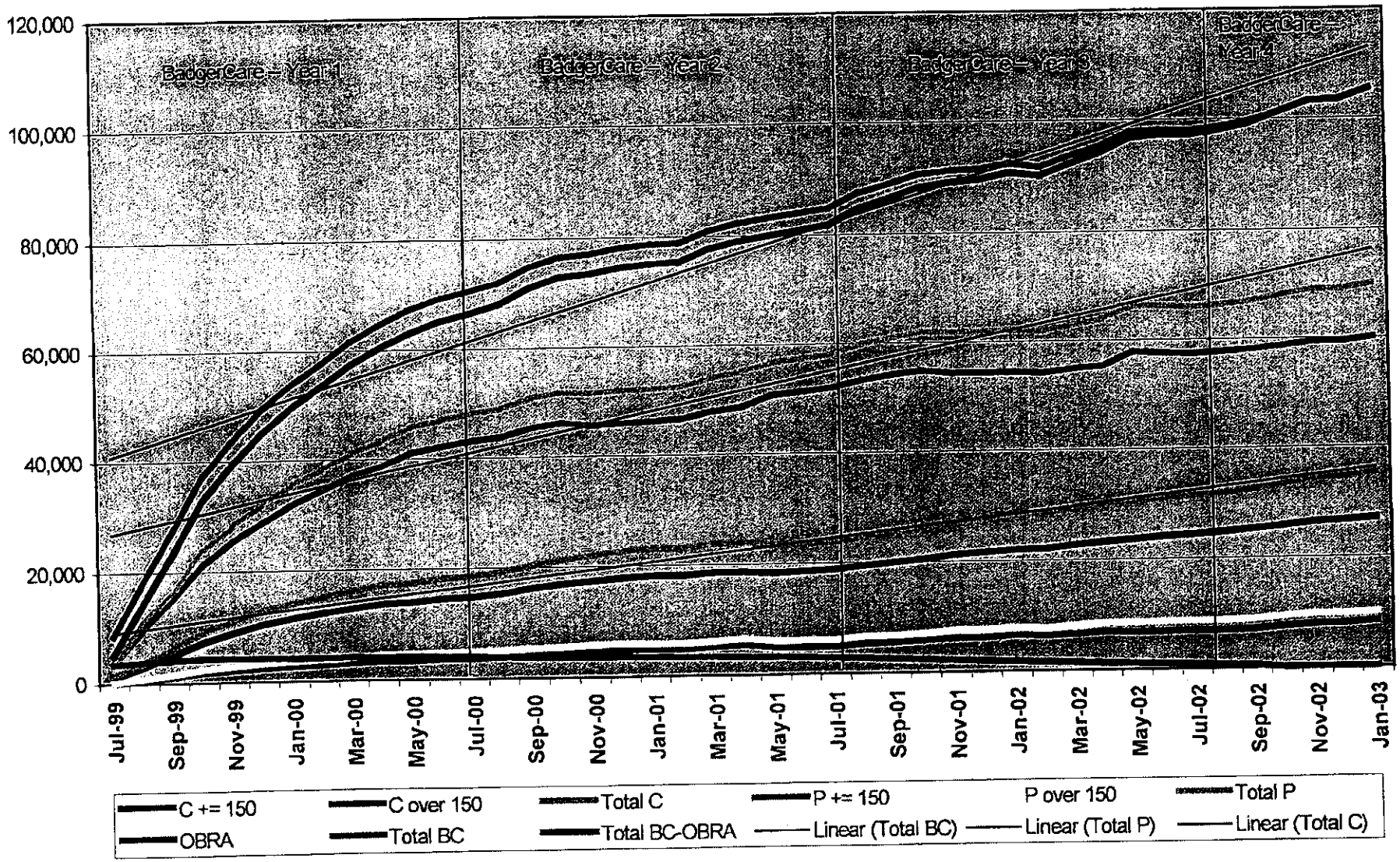
Appendix A

The graph on the following page shows enrollment in BadgerCare from July 1999 to February 2003. Following the steep uptake in enrollment during the first year of BadgerCare, the most notable element of this enrollment graph is the lack of sharp peaks or troughs. Rather, enrollment in BadgerCare, as indicated by the respective trend lines, is that enrollment has grown at a fairly steady pace. According to the data, enrollment in BadgerCare has increased at a monthly average of 2,286 people. If the high growth first year is subtracted from this total, average monthly enrollment increased by 1,230 people. We believe it is this figure that represents a more accurate portrayal of average enrollment growth in BadgerCare.

The monthly average enrollment declined in almost each year of the BadgerCare program. For example, in the high growth start up year of BadgerCare from July 1999 through June 2000, enrollment in BadgerCare increased by an average of 5,454 people per month. In the second year, from July 2000, to June 2001, this growth dropped to an average enrollment increase of 1,309 people per month. In the third year of BadgerCare, average enrollment increased slightly to 1,361 people per month. The first eight months of the fourth year of BadgerCare saw enrollment growth again slowing to an average enrollment gain of 1,018 people per month.

The graph demonstrates that, overall, enrollment growth in BadgerCare has remained rather constant. While at some point we expect to see monthly BadgerCare enrollment growth stabilize, we have not seen indications of this stabilization yet.

BadgerCare Enrollment
July 1999 to January 2003



MC03084.GD/PERM

Appendix B

Appendix B

Services Under the Wisconsin Medicaid Program

- Physicians' services
- Early and periodic screening, diagnosis and treatment (EPSDT) of persons under 21 years of age
- Rural health clinic services
- Medical services if prescribed by a physician:
  - Inpatient hospital services other than services in an institution for mental disease (IM D)
  - Outpatient hospital services
  - Skilled nursing home services other than in an IM D
  - Home health services, or nursing services if a home health agency is unavailable
  - Laboratory and x-ray services
  - Family planning services and supplies
  - Intermediate care facility (ICF) services, other than IMD services
  - Physical and occupational therapy
  - Speech, hearing and language disorder services
  - Medical supplies and equipment
  - Inpatient hospital, skilled nursing facility and ICF services for patients in IMDs:
    --who are under 21 years of age
    --are under 22 years of age and received services immediately prior to reaching age 21
    --who are 65 years of age or older
  - Medical day treatment, mental health and alcohol and other drug abuse services, including services provided by a psychiatrist
  - Nursing services, including services performed by a nurse practitioner
  - Legend drugs and over-the-counter drugs listed in the W isconsin's Medicaid drug index
  - Personal care services
  - Alcohol and other drug abuse day treatment services
  - Mental health and psychosocial rehabilitative services, including case management services, provided by staff of a certified community support program
  - Respiratory care services for ventilator-dependent individuals
- Dentists' services
- Nurse midwifery services
- Optometrists' or opticians' services, including eyeglasses
- Transportation:
  - By emergency medical vehicle to obtain emergency medical care
  - By specialized medical vehicle to obtain medical care
  - By common carrier or private motor vehicle if authorized in advance by a county
- Chiropractors' services
- Home and community-based services authorized under a waiver
- Case management services
- Hospice care
- Podiatrists' services
- Care coordination for women with high-risk pregnancies
- Care coordination and follow-up of persons having lead poisoning or lead exposure, including lead inspections
- Premiums, deductibles and coinsurance and other cost-sharing obligations for services otherwise paid under Medicaid that are required for enrollment in a group health plan
- Payment of any of the deductible and co-insurance portions of the services listed above which are paid under Medicare and the monthly Part B premiums payable under the federal Social Security Act
- Prenatal, post partum and young child care coordination services for certain residents of M ilwaukee County
- Mental health crisis intervention services
- School medical services

Appendix C

CARE ANALYSIS PROJECT (CAP): ASTHMA CY2001

MANAGED CARE ORGANIZATION SUMMARY: [HMO NAME]

This report presents an analysis of the quality of asthma care management in the Medicaid managed care population during calendar year (CY) 2001 (January 1, 2001, through December 31, 2001). The report is organized in four sections:

1) ASTHMA PREVALENCE. The eligible population is defined, and asthma prevalence in Medicaid managed care is estimated. Variations in prevalence among age groups, gender and eligibility categories are also shown.

2) ASTHMA SERVICE UTILIZATION. Data and accompanying charts on asthma-related service utilization by Medicaid managed care enrollees are reported for [HMO Name] to assist your organization in targeting Quality Improvement efforts.

3) ASTHMA CARE MANAGEMENT QUALITY. The Asthma Care Management Quality Index is presented to measure and compare the risk-adjusted quality of asthma care management in each managed care organization (MCO). Components of the Quality Index are explained, showing how specific measures of asthma care utilization by enrollees in [HMO Name] contribute to the overall quality score.

4) ANNUAL CHANGE IN QUALITY. The Asthma Care Management Quality Index is compared between the current year and the prior year. Significant quality improvements or declines are summarized for each MCO.

ASTHMA PREVALENCE

The prevalence of asthma is presented for a subset of Medicaid MCO enrollees. The eligible population includes Medicaid recipients 2 to 64 years of age who were enrolled in a single MCO for at least 259 days in calendar year (CY) 2001 (January 1, 2001, through December 31, 2001). Enrollees were identified as having asthma if they had a claim or encounter *at any point in time prior to the reporting end date* that met one or more of the following criteria:

- asthma-related inpatient hospitalization
- asthma-related emergency department visit
- asthma-specific medication
- asthma-related outpatient visit AND asthma-related medication

Enrollees who met the above criteria were subject to the additional criterion of having evidence of asthma treatment in the *2-year timeframe prior to the reporting end date*. A diagnosis of asthma (493.xx) on any diagnosis field or an asthma-specific or asthma-related medication indicated on a claim or encounter during this period constitutes evidence of an active asthma condition. This restriction eliminates individuals who may have a history of asthma but have not been treated recently, such as adults whose childhood asthma has resolved.

Asthma prevalence rates for [HMO Name] are displayed in the following table by age group, gender and eligibility category.

[HMO NAME]: BADGERCARE				
		Denominator	*Numerator*	*Prevalence Rate*
2-21 years old				
	Female	1,269	107	8.4%
	Male	1,153	112	9.7%
22-64 years old				
	Female	2,629	225	8.6%
	Male	1,487	52	3.5%
All BadgerCare		**6,538**	**496**	**7.6%**

[HMO NAME]: OTHER MEDICAID				
		Denominator	*Numerator*	*Prevalence Rate*
2-21 years old				
	Female	4,227	357	8.4%
	Male	4,125	397	9.6%
22-64 years old				
	Female	1,258	164	13.0%
	Male	241	15	6.2%
All Other Medicaid		**9,851**	**933**	**9.5%**

TOTAL [HMO NAME]: BADGERCARE AND OTHER MEDICAID			
	16,389	**1,429**	**8.7%**

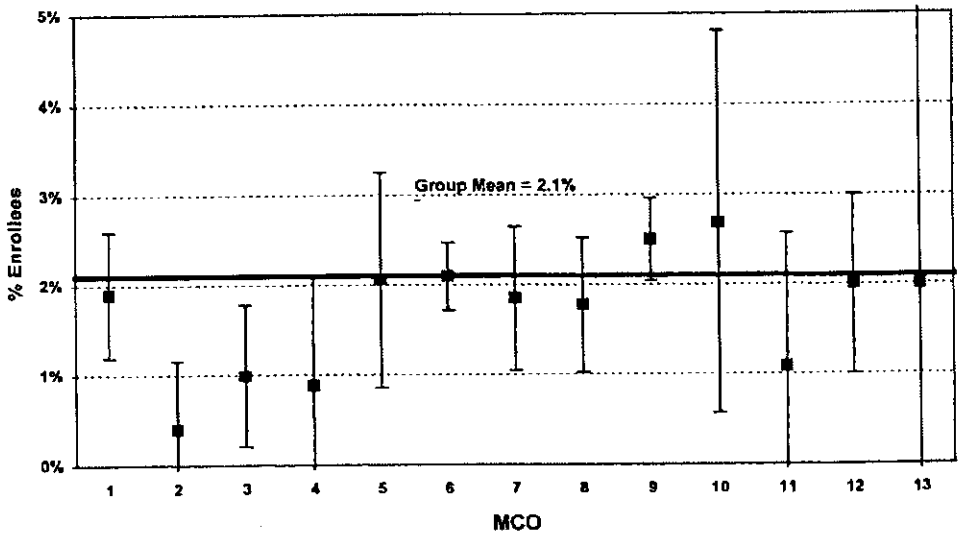
TOTAL MANAGED CARE: BADGERCARE AND OTHER MEDICAID			
	180,570	**16,369**	**9.1%**

HOSPITAL ADMISSIONS

For the 16,369 enrollees in the managed care population who were identified as having asthma and met the eligibility criteria, 336 (2.1%) had a hospital admission specific to asthma in CY 2001. Of [HMO Name]'s 1,429 enrollees diagnosed with asthma, 27 (1.9%) had an asthma-specific hospital admission in CY 2001. An asthma-specific hospital admission is defined as an inpatient hospital stay associated with an ICD-9 diagnosis of asthma (493.xx) recorded on the primary diagnosis field.

Chart A compares the 13 MCOs' percentage of unduplicated enrollees with one or more asthma-specific hospital admissions in CY 2001. The mean percentage for *all* 13 MCOs is 2.1%. [HMO Name]'s plot can be identified by the randomly assigned MCO code 0, and, according to the 95% Confidence Interval, is statistically indistinguishable from the overall mean of asthma-specific hospital admissions.

Chart A. Enrollees Diagnosed with Asthma with One or More Hospital Admissions in CY2001.*

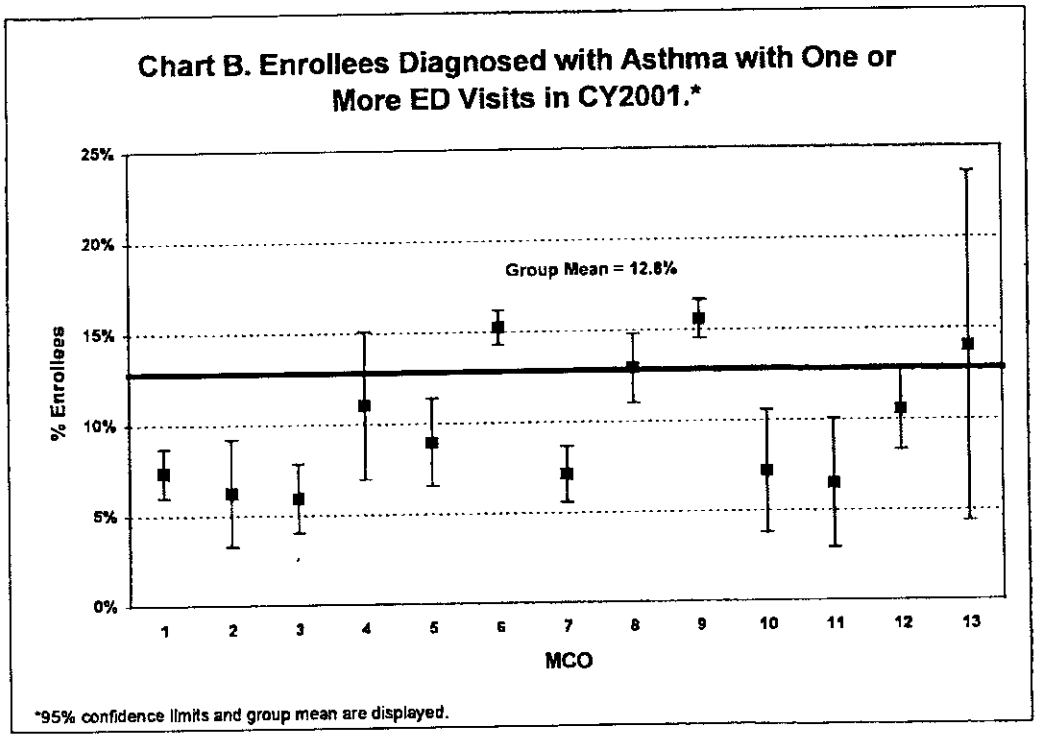


*95% confidence limits and group mean are displayed.

EMERGENCY DEPARTMENT VISITS

For the 16,369 enrollees in the managed care population who were identified as having asthma and met the eligibility criteria, 2,088 (12.8%) had an emergency department (ED) visit specific to asthma in CY 2001. Of [HMO Name]'s 1,429 enrollees diagnosed with asthma, 105 (7.3%) had an asthma-specific ED visit in CY 2001. An asthma-specific ED visit is defined as emergency department care associated with an ICD-9 diagnosis of asthma (493.xx) recorded on the primary diagnosis field.

Chart B compares the 13 MCOs' percentage of unduplicated enrollees with one or more asthma-specific emergency department visits in CY 2001. The mean percentage for *all* 13 MCOs is 12.8%. [HMO Name]'s plot can be identified by the randomly assigned MCO code 0, and, according to the 95% Confidence Interval, is significantly below the overall mean of asthma-specific ED visits.

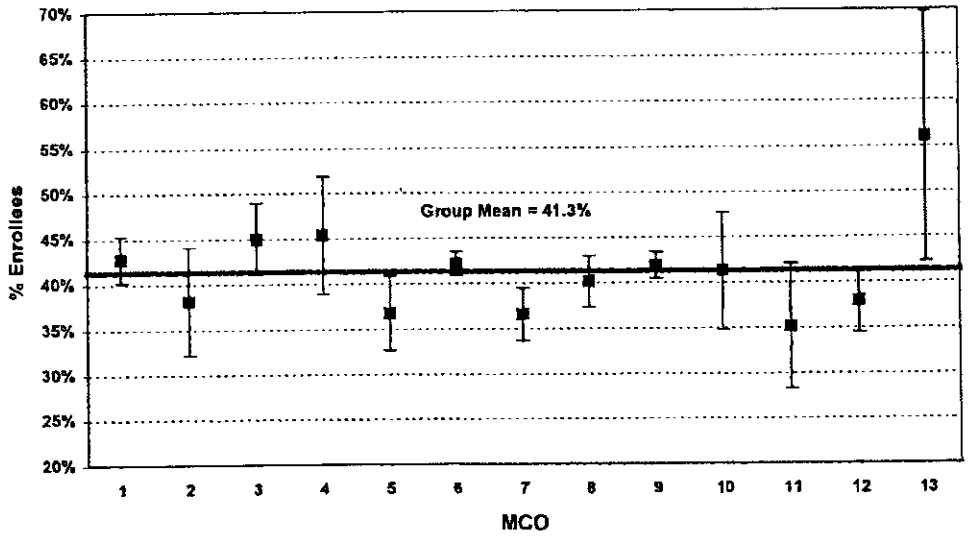


OUTPATIENT VISITS (ANY SPECIALTY)

For the 16,369 enrollees in the managed care population who were identified as having asthma and met the eligibility criteria, 6,757 (41.3%) had an outpatient visit specific to asthma in CY 2001. Of [HMO Name]'s 1,429 enrollees diagnosed with asthma, 611 (42.8%) had an asthma-specific outpatient visit in CY 2001. An asthma-specific outpatient visit is defined as an ambulatory office visit with a physician of any type or specialty, associated with an ICD-9 diagnosis of asthma (493.xx) recorded on the primary diagnosis field.

Chart C compares the 13 MCOs' percentage of unduplicated enrollees with one or more asthma-specific outpatient visits in CY 2001. The mean percentage for *all* 13 MCOs is 41.3%. [HMO Name]'s plot can be identified by the randomly assigned MCO code 0, and, according to the 95% Confidence Interval, is statistically indistinguishable from the overall mean of asthma-specific outpatient visits.

Chart C. Enrollees Diagnosed with Asthma with One or More Outpatient Visits in CY2001.*

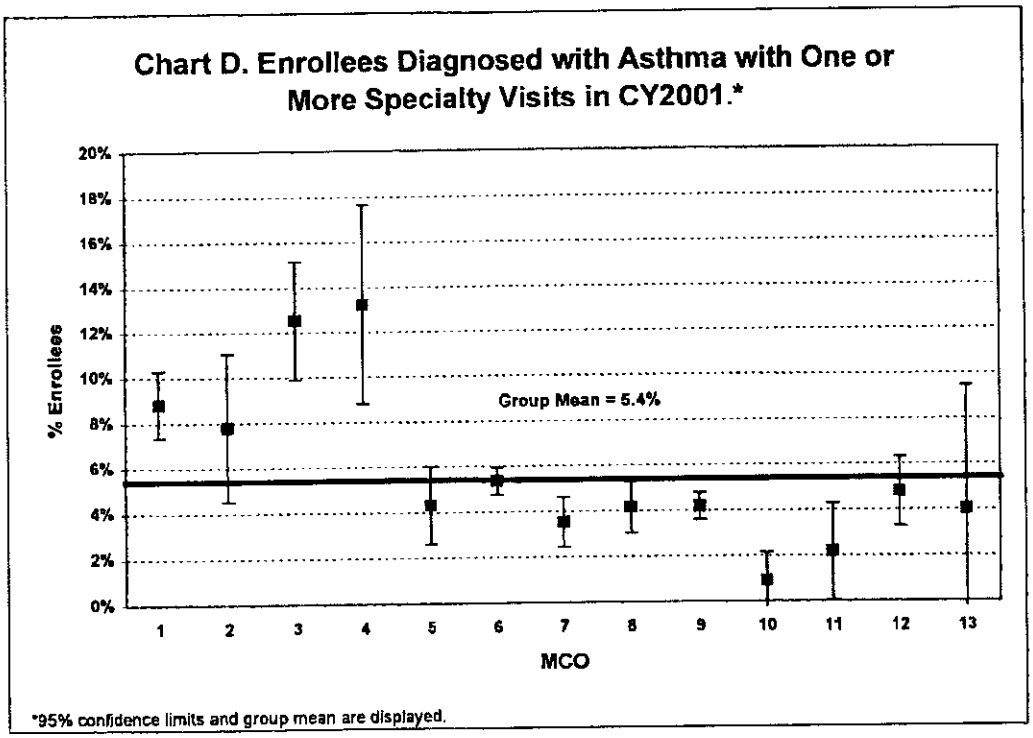


*95% confidence limits and group mean are displayed.

SPECIALTY VISITS (ANY PLACE OF SERVICE)

For the 16,369 enrollees in the managed care population who were identified as having asthma and met the eligibility criteria, 879 (5.4%) had a specialty visit specific to asthma in CY 2001. Of [HMO Name]'s 1,429 enrollees diagnosed with asthma, 126 (8.8%) had an asthma-specific specialty visit in CY 2001. An asthma-specific specialty visit is defined as a visit to a specialist in the area of allergy, pediatric allergy, pulmonary disease, or otorhinolaryngology at any place of service, where the visit is associated with an ICD-9 diagnosis of asthma (493.xx) recorded on the primary diagnosis field.

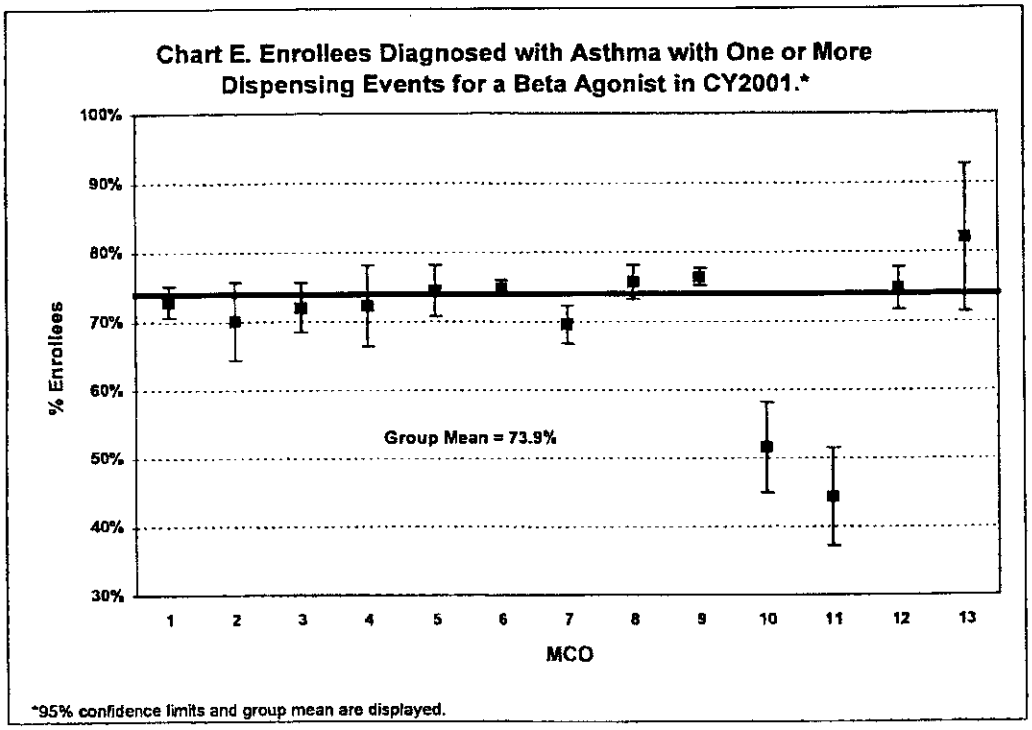
Chart D compares the 13 MCOs' percentage of unduplicated enrollees with one or more asthma-specific specialty visits in CY 2001. The mean percentage for *all* 13 MCOs is 5.4%. [HMO Name]'s plot can be identified by the randomly assigned MCO code 0, and, according to the 95% Confidence Interval, is significantly above the overall mean of asthma-specific specialty visits.



Rx: Beta Agonists

For the 16,369 enrollees in the managed care population who were identified as having asthma and met the eligibility criteria, 12,095 (73.9%) had at least one dispensing event for a beta agonist in CY 2001. Of [HMO Name]'s 1,429 enrollees diagnosed with asthma, 1,041 (72.8%) had at least one dispensing event for a beta agonist in CY 2001.

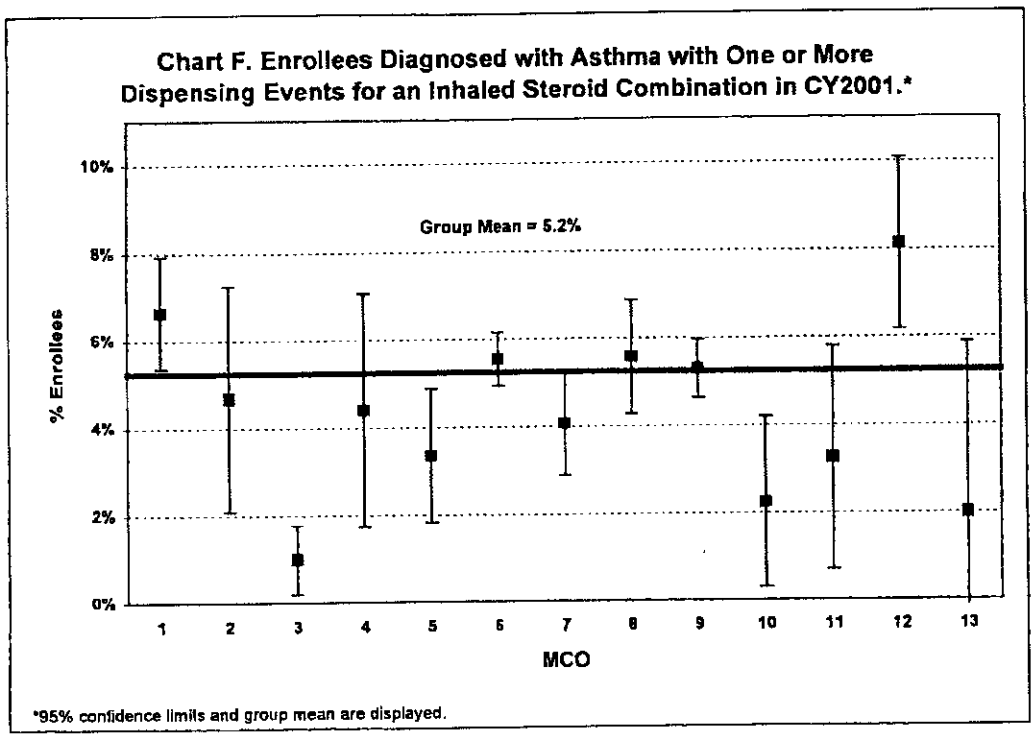
Chart E compares the 13 MCOs' percentage of unduplicated enrollees with one or more dispensing events for a beta agonist in CY 2001. The mean percentage for *all* 13 MCOs is 73.9%. [HMO Name]'s plot can be identified by the randomly assigned MCO code 0, and, according to the 95% Confidence Interval, is statistically indistinguishable from the overall mean of dispensing events for a beta agonist.



Rx: Inhaled Steroid Combinations

For the 16,369 enrollees in the managed care population who were identified as having asthma and met the eligibility criteria, 858 (5.2%) had at least one dispensing event for an inhaled steroid combination in CY 2001. Of [HMO Name]'s 1,429 enrollees diagnosed with asthma, 95 (6.6%) had at least one dispensing event for an inhaled steroid combination in CY 2001.

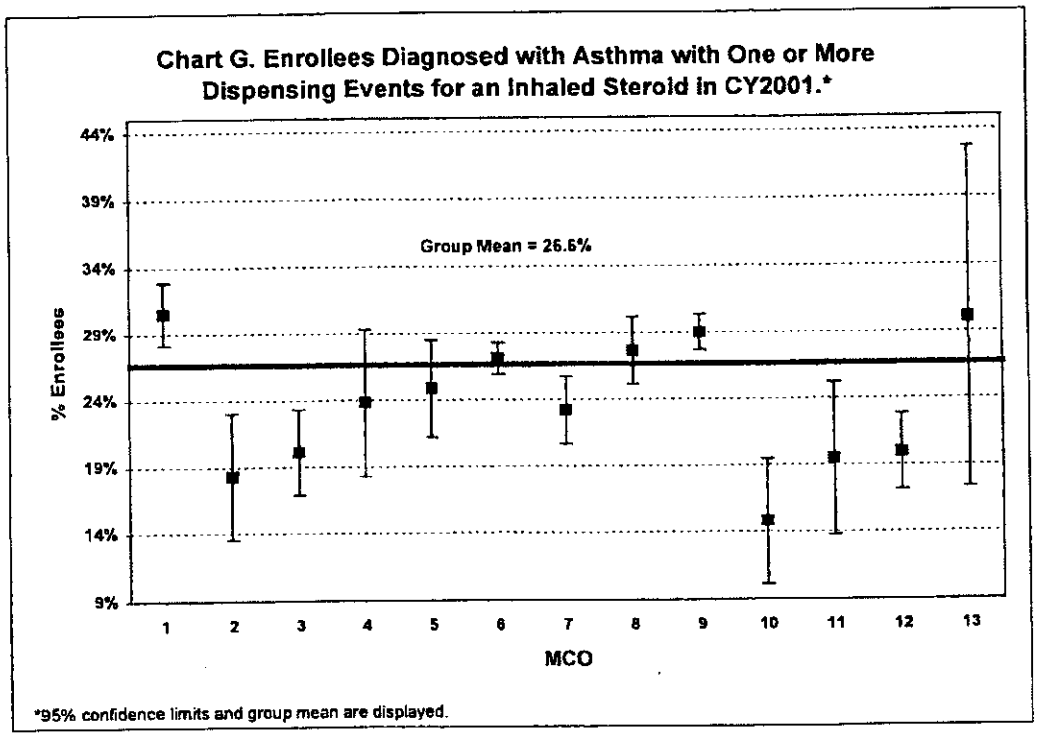
Chart F compares the 13 MCOs' percentage of unduplicated enrollees with one or more dispensing events for an inhaled steroid combination in CY 2001. The mean percentage for *all* 13 MCOs is 5.2%. [HMO Name]'s plot can be identified by the randomly assigned MCO code 0, and, according to the 95% Confidence Interval, is significantly above the overall mean of dispensing events for an inhaled steroid combination.



RX: INHALED STEROIDS

For the 16,369 enrollees in the managed care population who were identified as having asthma and met the eligibility criteria, 4,352 (26.6%) had at least one dispensing event for an inhaled steroid in CY 2001. Of [HMO Name]'s 1,429 enrollees diagnosed with asthma, 436 (30.5%) had at least one dispensing event for an inhaled steroid in CY 2001.

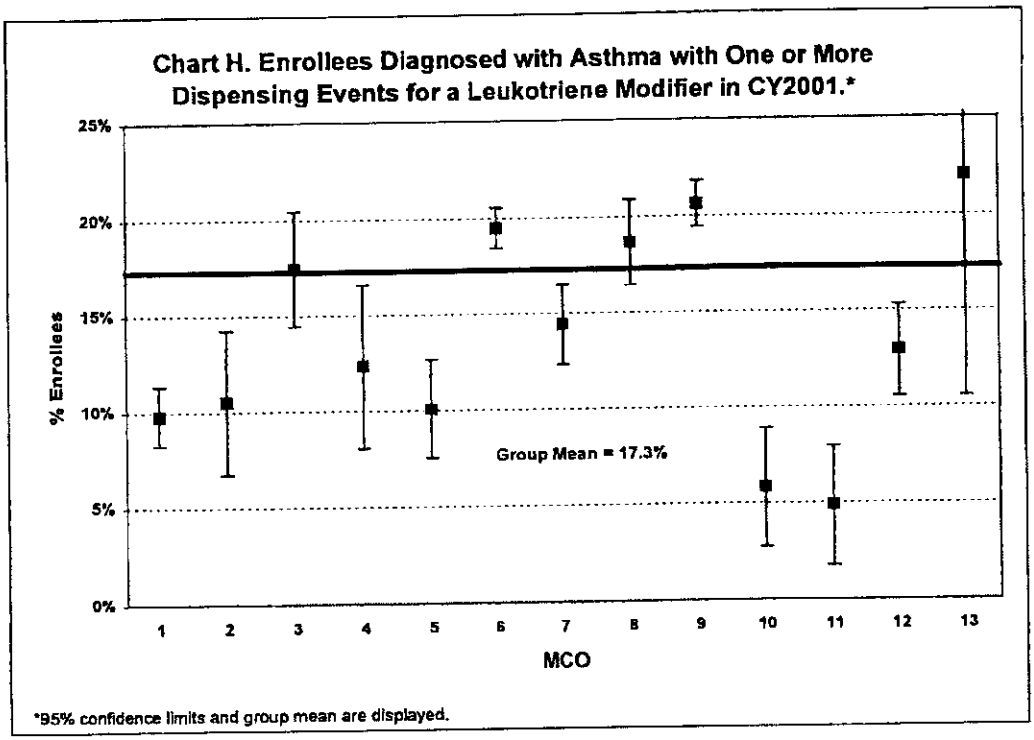
Chart G compares the 13 MCOs' percentage of unduplicated enrollees with one or more dispensing events for an inhaled steroid in CY 2001. The mean percentage for *all* 13 MCOs is 26.6%. [HMO Name]'s plot can be identified by the randomly assigned MCO code 0, and, according to the 95% Confidence Interval, is significantly above the overall mean of dispensing events for an inhaled steroid.



Rx: Leukotriene Modifiers

For the 16,369 enrollees in the managed care population who were identified as having asthma and met the eligibility criteria, 2,830 (17.3%) had at least one dispensing event for a leukotriene modifier in CY 2001. Of [HMO Name]'s 1,429 enrollees diagnosed with asthma, 140 (9.8%) had at least one dispensing event for a leukotriene modifier in CY 2001.

Chart H compares the 13 MCOs' percentage of unduplicated enrollees with one or more dispensing events for a leukotriene modifier in CY 2001. The mean percentage for *all* 13 MCOs is 17.3%. [HMO Name]'s plot can be identified by the randomly assigned MCO code 0, and, according to the 95% Confidence Interval, is significantly below the overall mean of dispensing events for a leukotriene modifier.

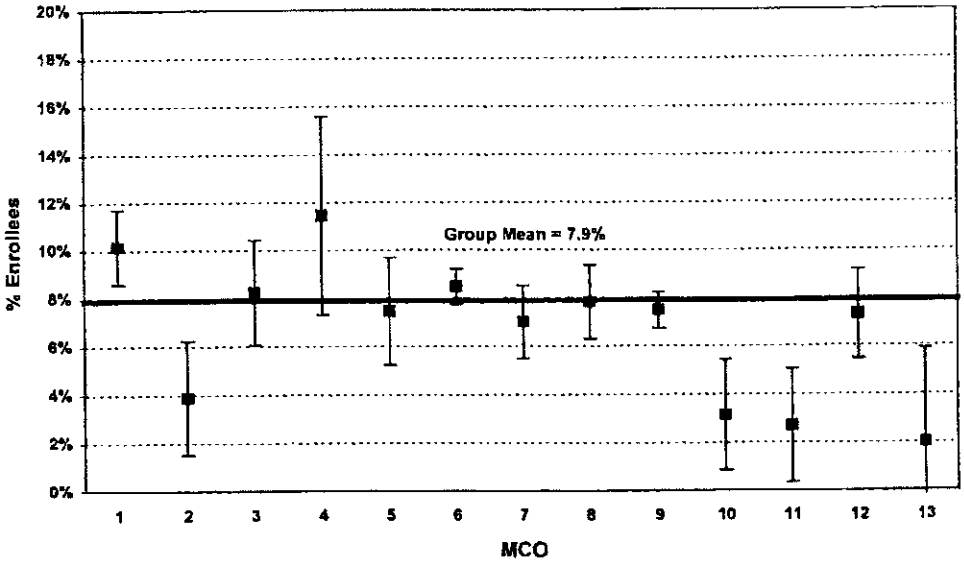


Rx: Long Acting Beta Agonists

For the 16,369 enrollees in the managed care population who were identified as having asthma and met the eligibility criteria, 1,299 (7.9%) had at least one dispensing event for a long acting beta agonist in CY 2001. Of [HMO Name]'s 1,429 enrollees diagnosed with asthma, 145 (10.1%) had at least one dispensing event for a long acting beta agonist in CY 2001.

Chart I compares the 13 MCOs' percentage of unduplicated enrollees with one or more dispensing events for a long acting beta agonist in CY 2001. The mean percentage for *all* 13 MCOs is 7.9%. [HMO Name]'s plot can be identified by the randomly assigned MCO code 0, and, according to the 95% Confidence Interval, is significantly above the overall mean of dispensing events for a long acting beta agonist.

Chart I. Enrollees Diagnosed with Asthma with One or More Dispensing Events for a Long Acting Beta Agonist in CY2001.*

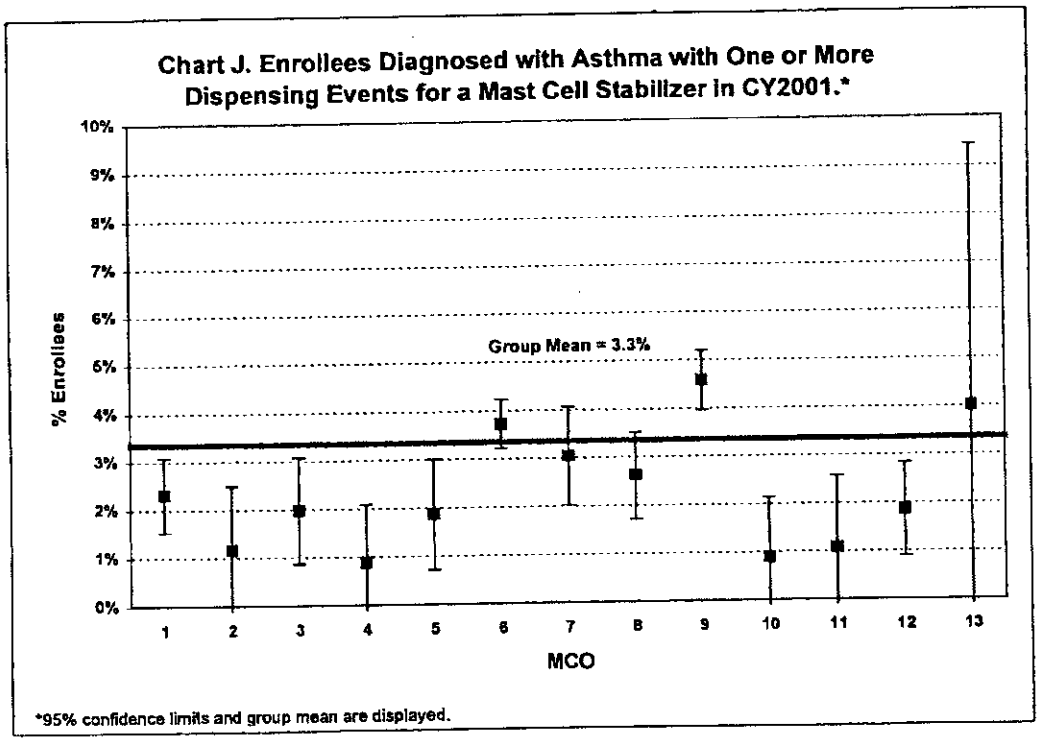


*95% confidence limits and group mean are displayed.

Rx: Mast Cell Stabilizers

For the 16,369 enrollees in the managed care population who were identified as having asthma and met the eligibility criteria, 548 (3.3%) had at least one dispensing event for a mast cell stabilizer in CY 2001. Of [HMO Name]'s 1,429 enrollees diagnosed with asthma, 33 (2.3%) had at least one dispensing event for a mast cell stabilizer in CY 2001.

Chart J compares the 13 MCOs' percentage of unduplicated enrollees with one or more dispensing events for a mast cell stabilizer in CY 2001. The mean percentage for *all* 13 MCOs is 3.3%. [HMO Name]'s plot can be identified by the randomly assigned MCO code 0, and, according to the 95% Confidence Interval, is significantly below the overall mean of dispensing events for a mast cell stabilizer.

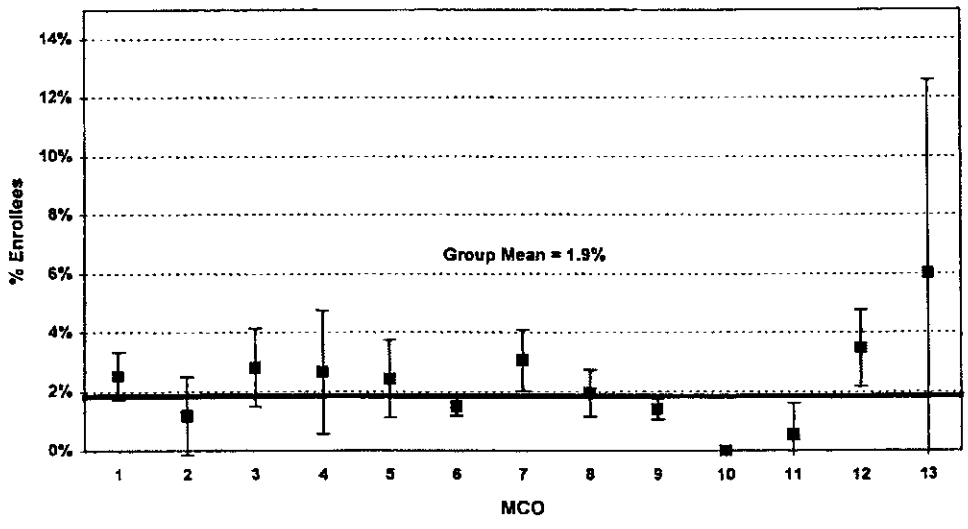


Rx: Xanthine Combinations, Xanthines, or Ipratropium

For the 16,369 enrollees in the managed care population who were identified as having asthma and met the eligibility criteria, 304 (1.9%) had at least one dispensing event for a xanthine combination, xanthine, or ipratropium in CY 2001. Of [HMO Name]'s 1,429 enrollees diagnosed with asthma, 36 (2.5%) had at least one dispensing event for a xanthine combination, xanthine, or ipratropium in CY 2001.

Chart K compares the 13 MCOs' percentage of unduplicated enrollees with one or more dispensing events for a xanthine combination, xanthine, or ipratropium in CY 2001. The mean percentage for *all* 13 MCOs is 1.9%. [HMO Name]'s plot can be identified by the randomly assigned MCO code 0, and, according to the 95% Confidence Interval, is statistically indistinguishable from the overall mean of dispensing events for a xanthine combination, xanthine, or ipratropium.

Chart K. Enrollees Diagnosed with Asthma with One or More Dispensing Events for a Xanthine Combination, Xanthine, or Ipratropium in CY2001.*



*95% confidence limits and group mean are displayed.

ASTHMA CARE MANAGEMENT QUALITY

ANALYTICAL MODEL

To distinguish MCOs with higher-than-average or lower-than-average quality of care management, quality must first be defined and measured. As there is no direct measure of care management quality, an indirect measure must be constructed.

We conceive of high-quality asthma management as having relatively high utilization of primary care services (such as office visits for asthma care) and relatively low utilization of secondary care (such as emergency department visits and inpatient hospitalizations). The utilization measures and their hypothetical relationship to asthma management quality are depicted in Figure 1, which shows that asthma management quality varies among MCOs, is positively related to measures of primary care, and is negatively related to measures of secondary care.

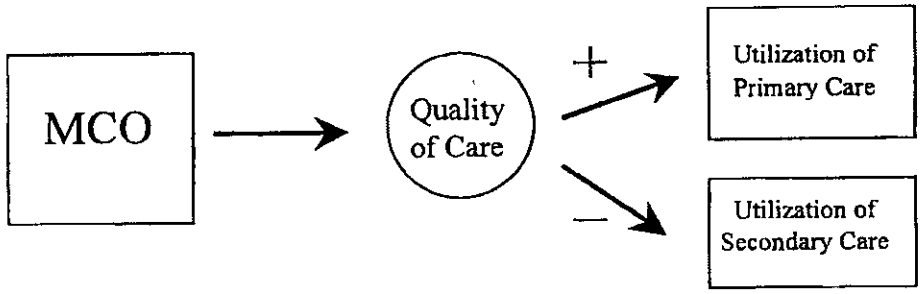


Figure 1. Conceptual relationship between MCO's quality of care, utilization of primary care, and utilization of secondary care.

One problem arises with utilization-based quality measures. A patient's utilization of health services varies in proportion to the severity of his or her condition. Thus, an MCO that serves a population of individuals with higher-than-average severity, or a population with a high admixture of severe cases, will have higher-than-average utilization rates of both primary and secondary care. To make a fair comparison on the basis of disease management quality, this overall effect of severity on utilization must be controlled, such that each MCO's disease management practices are compared for populations of similar average disease severity and case mix. Lacking the ability to randomly assign patients to different MCOs, we must rely on statistical control to adjust for the overall risk of healthcare utilization, thereby making a risk-adjusted comparison of disease management quality across MCOs.

For this project, factor analysis was used to estimate the independent effects of asthma severity and asthma care management quality on asthma-related health service utilization. The factor-score regression formula was used to compute the risk-adjusted Asthma Care Management Quality Index as the weighted sum of asthma care utilization measures that are positively related to primary care and negatively related to emergency and hospital care, after adjusting for overall utilization risk due to severity. Analysis of Variance was applied to the Quality Index to detect statistically significant variation between MCOs while accounting for differences in size and variation within MCOs.

SUMMARY RESULTS

Figure 2 shows the distribution of average quality scores for 13 MCOs, with error bars to show the 95% Confidence Interval for the mean score, relative to the mean for all MCOs.*

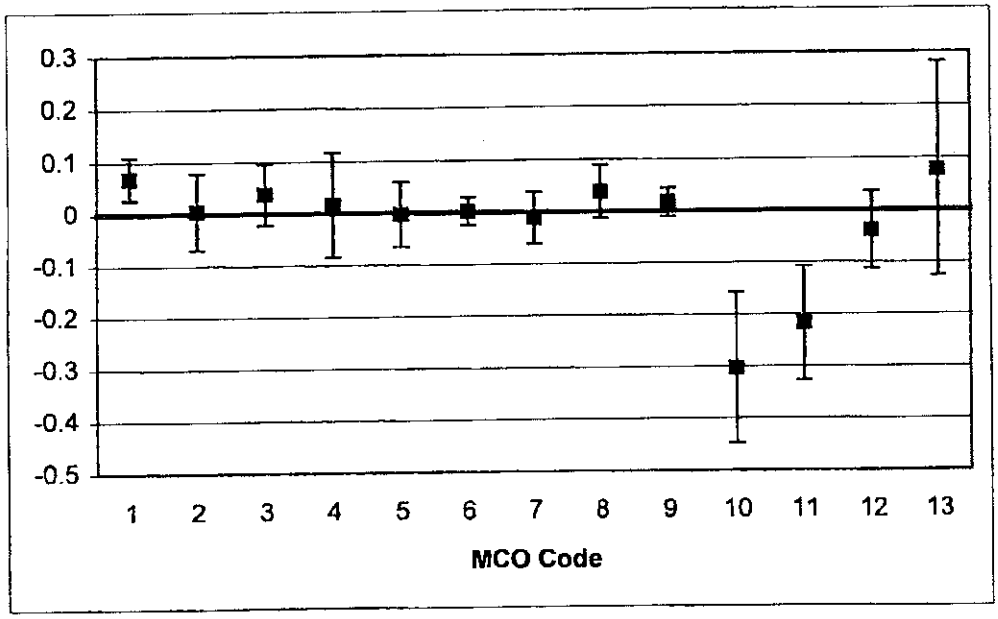


Figure 2. Risk-Adjusted Asthma Care Management Quality Scores for 13 Wisconsin MCOs in CY 2001.

The data in Figure 2 show that while most MCOs have care management quality scores that are statistically indistinguishable from the mean (at a 5% level of significance), one MCO (1) is significantly higher than average, and two MCOs (10 and 11) are significantly below the average. Compared to their peers, these last two MCOs have relatively lower-than-average primary care utilization and higher-than-average secondary care utilization, given the overall risk of asthma-related healthcare utilization in the populations they serve. **[HMO Name] can be identified by the randomly assigned MCO code 0.**

* The size (width) of the 95% Confidence Interval is quite sensitive to the size of the measured population. In general, the greater the number of enrollees with asthma, the smaller the Confidence Interval. In Figure 2, MCO 6 has the greatest number of enrollees with asthma (n = 5,397) while MCO 13 has the fewest (n = 50).

COMPONENTS OF CARE

The care management quality score can be separated into components of care that correspond to the data reported in the preceding section titled *Asthma Service Utilization*. The Asthma Care Management Quality Index is computed with the equation:

Q-Score =

(Number of Asthma Hospital Admissions	x	-0.56) +
(Number of Asthma Emergency Department visits	x	-0.50) +
(Number of Asthma Office Visits	x	+0.10) +
(Beta Agonist prescription was filled 1 or more times	x	+0.31) +
(Inhaled Steroid prescription was filled 1 or more times	x	+0.25) +
(Long-Acting Beta Agonist prescription was filled 1 or more times	x	+0.16) +
(Inhaled Steroid Combination prescription was filled 1 or more times	x	+0.09) +
(Leukotriene Modifier prescription was filled 1 or more times	x	+0.18) +
(Number of Asthma Specialist Visits	x	-0.10) +
(Xanthine or Ipratroprium prescription was filled 1 or more times	x	-0.15) +
(Mast Cell Stabilizer prescription was filled 1 or more times	x	-0.11)

The summary index score is simply the weighted sum of risk-adjusted utilization for asthma-related healthcare services. The weights are factor-score regression coefficients from a factor analysis model that controls for overall utilization risk. Positive coefficients indicate that "quality" *rises* as the utilization of the associated health service increases, and negative coefficients indicate that "quality" *declines* as the utilization of the associated health service increases. For example, the negative coefficients for emergency and hospital visits mean that "quality" is lower for people or populations with higher levels of risk-adjusted emergency and hospital utilization, other things equal.

With other things held equal, MCOs with Medicaid recipients using the six positive asthma care components more than average tend to have higher-than-average asthma care management quality. These components include office visits for asthma care, and prescriptions for Beta Agonists, Long-Acting Beta Agonists, Inhaled Steroids and combinations, and Leukotriene Modifiers.

The service utilization charts shown in the previous section indicate where [HMO Name] members may have relatively higher or lower utilization of the asthma-related primary care and preventive measures that comprise the Asthma Care Management Quality Index. Thus, you may use the charts to focus your Quality Improvement efforts on increasing those positive measures with relatively low utilization, or by decreasing the negative measures with relatively high utilization.

ANNUAL CHANGE IN ASTHMA CARE MANAGEMENT QUALITY

Using data from consecutive years, this section shows the annual change in asthma care management quality scores. Figure 3 illustrates the quality scores for the current year (2001) compared to the previous year (2000), using the formula given above to calculate quality scores in each year.

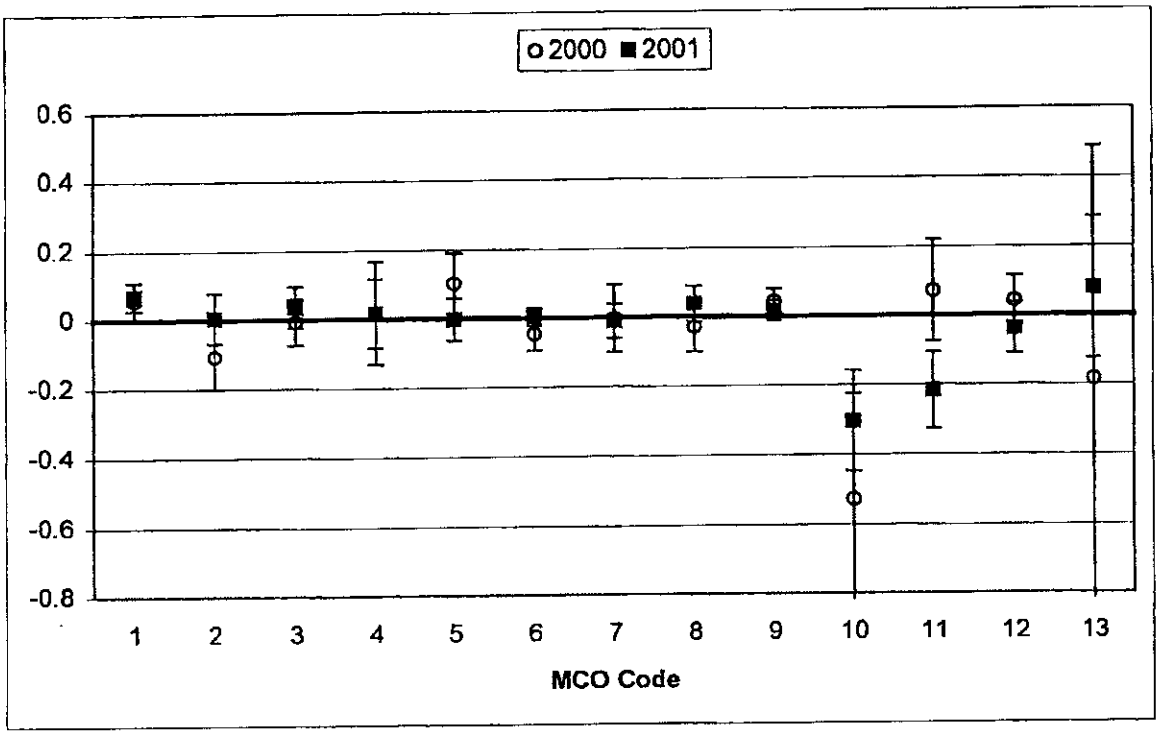


Figure 3. Risk-Adjusted Asthma Care Management Quality Scores for 13 Wisconsin MCOs in CY 2001 and 2001.

The figure shows that six MCOs have a tendency toward rising quality, while four MCOs show lower scores in 2001 compared to 2000. Only in one case was the annual difference statistically significant, as indicated by non-overlapping 95% confidence interval error bars in Figure 3. MCO 11 registered a significant decline in asthma care management quality from the year 2000 to 2001.

Appendix D

Wisconsin Medicaid Quality Improvement Projects

Review and Evaluate HMOs, SMCOs and FFS

- Independent Care (I Care) Review
- PACE/WPP (CLA, Eldercare, CHP, CCE) Review
- Milwaukee Wrap-Around (WAM) and Children Come First (CCF) Combined Review

Review and Evaluate Dental Services

- Oral Health Grant

Recipient and Public Feedback Mechanisms

- Mental Health/AODA Provider Survey
- CAHPS Survey--Medicaid Managed Care/BadgerCare/FFS

Improve HMO Reporting & Data Collection

- Enrollee Health Needs Assessment Development and Implementation
- Data Validity Audit of CY 2001 HMO Encounter Data
- HMO Comparison Report (CY2000 & CY2001 combined)
- Primary Care for Children and Adolescents Improvement Incentive
- MEDDIC-MS Phase II: Implementation

HMO QI Performance Improvement Projects

- HMO Performance Improvement Projects (2001)
- Best Practices Seminar

SMCO QI Performance Improvement Projects

- SMCO Performance Improvement Projects (PACE/WPP)

EQRO Activities

- Certificate of Need (CON) Reviews
- Inpatient FFS Hospital Review
- Inpatient FFS Hospitalization (medical/surgical)
- Medicaid HMO Emergency Room Services Audit
- Diabetes (Lipid/Hemoglobin) Study

Care Analysis Projects

- FFS Diabetes Targeted Intervention
- Improving Birth Outcomes Project (IBOP)
- HMO Tobacco Targeted Intervention
- Acute Myocardial Infarction (AMI) Targeted Intervention
- HMO Profiles (Women, Children, Chronic Conditions and Mental Health/Substance Abuse Services
- HMO Diabetes Targeted Intervention
- FFS Lead Data Targeted Intervention
- HMO Lead Data Targeted Intervention
- FFS Asthma Case Management Pilot

WI Medicaid Program Reports

- HMO Report Card (for CY2002)

Appendix E

Health Needs Screening Brief Enrollee Survey (Ph v.4)
State of Wisconsin, DHFS

Automated Health Systems
633 West Wisconsin Avenue
Suite 301
Milwaukee, Wisconsin 53203
(414) 221-9300

Taken by: Teresa Bender on: 07/03/2002 08:06:04 AM

Enrollee Name:	MAID #
Address: ,	Phone:
New HMO:	Birth Date:

Explanation To Enrollees (Mandatory for all telephone and written survey contacts)

Participation in this survey is voluntary and you may choose to not answer any or all of the questions. The survey is very brief and the information you give will be used to help the HMO you choose meet your health care needs. Your answers are confidential and will be shared only with the HMO that you may choose to enroll in and their health care providers. Feel free to ask me questions as we go along. Thanks for your help.

- Survey -

Questions	Response	Comments
1. Are there any additional phone numbers that can be used to reach you.	● Y ○ N ○ NR	ListNumbers:
2. Are there other people we can contact if we need to reach you?	● Y ○ N ○ NR	Name: Phone: Name: Phone:
3. What is the Primary Language used in your family?		○ English ○ Hmong ○ Other ○ Spanish ○ Russian Other: ○ Read ○ Spoken
4. Do you anticipate moving from your present address in the next six months?	● Y ○ N ○ NR	
5. Have you seen a doctor or other medical person for any illness or injury in the past year?	● Y ○ N ○ NR	Why?
6. Do you have a doctor or medical person that you consider your regular or family doctor?	● Y ○ N ○ NR	Name: Clinic:
7. Have you been in the hospital in the past year?	● Y ○ N ○ NR	Why?
8. Has your child or member of your family been in the hospital?	● Y ○ N ○ NR	Who? Why?
9a. Do you or any member of your family have medical conditions that need regular care or prescription medications? **Examples:** **Asthma ("attacks" or difficult breathing)** ○ Y ○ N **Diabetes (high or low blood sugar)** ○ Y ○ N **High Blood Pressure** ○ Y ○ N **Heart Problems** ○ Y ○ N	● Y ○ N ○ NR	**Detail:** **Do any of these conditions limit or prevent any routine daily activities?** ● Y ○ N **Have any of these conditions lasted or are expected to last at least 12 months?** ● Y ○ N

Disabilities (blind, deaf, wheelchair bound, etc.) ○ Y ○ N **Other** ○ Y ○ N		
9b. Do you or any member of your family have a scheduled procedure or surgery?	● Y ○ N ○ NR	**Who?** **Procedure:** **Dates:**
10. Are you or any member of your family pregnant?	● Y ○ N ○ NR	**Estimated Due Date:** **Pregnant Individual:**
11. Do you have children under the age of 21 living at home?	● Y ○ N ○ NR	**How Many?** **Foster Care?**
12. Are you enrolled in the Birth to Three Program?	● Y ○ N ○ NR	
13. Do you know the phone number to get help with Medicaid or BadgerCare problems or questions? **Enrollment: (800) 291-2002** **EDS Ombudsman: (800) 760-0001**		
14. Will you need assistance with transportation to/from doctor or dental appointments?	● Y ○ N ○ NR	
15. Do you or a member of your family smoke cigarettes or use any other tobacco products?	● Y ○ N ○ NR	**Who?** **Interested in help quiting?**
16. Have you or any of your family members ever received a transplant (other than cornea or kidney)?	● Y ○ N ○ NR	

Any other follow-up or questions from enrollee

Appendix F

Best Practices Seminar
May 8, 2003

The Wisconsin Medicaid program partners with 13 Wisconsin managed care organizations to bring high quality health care to Wisconsin citizens enrolled in Medicaid and BadgerCare. As part of the Medicaid program's quality improvement efforts, each HMO is required to conduct two Performance Improvement Projects annually. Each study selects a health care issue of high relevance to Medicaid/BadgerCare recipients and is designed to improve care delivery. These Performance Improvement Projects have the potential to identify "best practices" that can be embraced throughout the Wisconsin Medicaid/BadgerCare system.

Each Performance Improvement Project is submitted for review by the Wisconsin Medicaid program. The "best of the best" are then showcased at the Best Practices Seminar, a public forum for presentation and discussion of selected studies. In the spirit of sharing, these studies are promoted to others as examples of sound performance improvement projects that can impact the quality of care provided to Wisconsin Medicaid/BadgerCare recipients.

The Division of Health Care Financing (DHCF) is pleased to announce that the discussion panel for this year's Best Practices Seminar includes:

- Jeff Davis, MD -- Department of Health and Family Services/Division of Public Health
- Michael Lynch, MD -- Medical Director, Managed Health Services and Network Health Plan
- Barbara Rudolph, PhD, MSSW -- University of Wisconsin-Center for Health Systems Research and Administration (CHSRA)
- Marvin Wiener, MD -- Medical Director, Unity Health Insurance

Come and learn what the Wisconsin Medicaid program and the HMOs are doing to improve health care quality in Wisconsin!

State of Wisconsin
Department of Health & Family Services
Division of Health Care Financing

Best Practices Seminar
Thursday, May 8, 2003, 9:00 a.m. to 3:30 p.m.
Monona Terrace
1 John Nolen Drive
Madison, Wisconsin
(608) 261-4000

AGENDA

8:30 a.m. **Registration**
9:00 a.m. **Welcome and Introductions** – Division of Health Care Financing (DHCF)
9:15 a.m. **DHCF Quality Improvement Initiatives** – DHCF
9:25 a.m. **Improving Lead Screening Rates** – UnitedHealthcare
9:55 a.m. **Panel Discussion**
10:15 a.m. **Break**
10:30 a.m. **Multifaceted Outreach and Education Program to Increase Influenza Immunizations** – Independent Care, Inc. (*i*Care)
11:00 a.m. **Panel Discussion**
11:20 a.m. **From Encounter Data to MEDDIC-MS to Profiles/TPIMs to CAPs to Case Management** – DHCF and APS Healthcare
12:00 p.m. **Break**
12:15 p.m. **Lunch and Keynote Speaker** – Nick A. Mezacapa
1:15 p.m. **Impact of OB Case Management on NICU Admission Rates** – Managed Health Services and Network Health Plan
1:45 p.m. **Panel Discussion**
2:05 p.m. **High-Risk OB** – Group Health Cooperative-Eau Claire and Atrium Health Plan
2:35 p.m. **Panel Discussion**
3:00 p.m. **Wrap Up** – DHCF
3:30 p.m. **Adjourn**

Registration Deadline: Friday, May 2, 2003

(Register now! Space is limited!)

REGISTRATION INFORMATION

Name: _____
Organization: _____
Address: _____
City/State/ZIP: _____
Day Phone: _____ Fax: _____
E-Mail: _____

There is no registration fee for this seminar.

Registration for the May 8, 2003 Seminar

☐ Yes! I will attend the Best Practices Seminar.
☐ No. I am not able to attend this seminar but I would like to remain on your mailing list for future events.

Please mail or fax your registration to:
Best Practices Seminar
Attn: Training Coordinators
6406 Bridge Road
Madison, WI 53784
Fax: (608) 221-0885 Phone: (608) 221-4746, ext. 3300

Register on-line at the Wisconsin Medicaid web site at:
www.dhfs.state.wi.us/medicaid/index.htm

BadgerCare pays for:

- ✓ Prevention services such as
  - Doctor visits
  - Prenatal care
  - Preventive checkups
  - Immunizations (shots)
- ✓ Vision care, including eyeglasses
- ✓ Prescription drugs
- ✓ Family planning services and supplies
- ✓ Speech therapy
- ✓ Mental health services
- ✓ Medical equipment
- ✓ Hospital care
- ✓ Hearing services, including hearing aids
- ✓ Lab and x-ray services
- ✓ Dental services
- ✓ Transportation to medical covered services
- ✓ Plus much more...

"BadgerCare can help keep your family healthy"

"I am proud of Wisconsin's BadgerCare program which provides health care coverage for uninsured working families – children up to age 19 and their parents."

— Governor Scott McCallum

Call and find out if you're eligible.

Call today — don't miss out on a benefit that could help you.

CALL: 1-800-362-3002
(TTY and translation services available.)

OR CONTACT:
The county/tribal social or human services department or local W-2 agency in your county.

Find out more at **www.dhfs.state.wi.us**

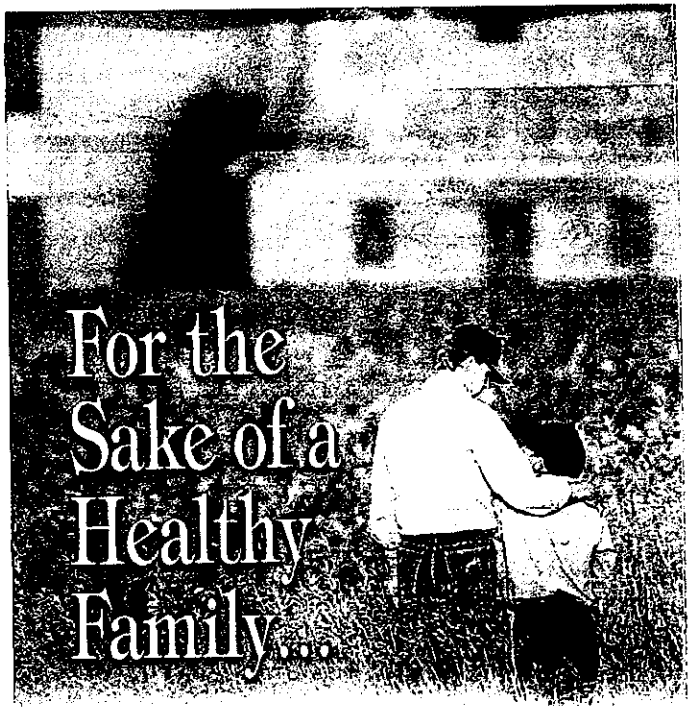
BadgerCare®
Health Insurance for Working Families

Department of Health and Family Services
Division of Health Care Financing
Bureau of Health Care Eligibility
PHC 1086 (09/01)

Health Care Coverage for Working Families

Find out if you're eligible for Wisconsin's BadgerCare!

BadgerCare®



For the Sake of a Healthy Family...

Find out if you are eligible for BadgerCare

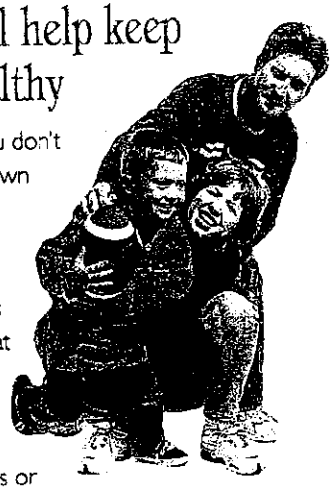
BadgerCare is Wisconsin's statewide program that provides health care coverage for uninsured working families.

By providing coverage for children up to age 19 **and** their parents, BadgerCare makes it easier for parents to create a happy and healthy family life.

To be eligible

- You must be a child under age 19 or a parent of a child under age 19 living with you.
- Your family income must be within the program limits.
- There is no limit on assets.
- You must not be covered by health insurance.
- If you recently were covered by health insurance, there is a 3-month waiting period, except with good cause. (An example of good cause would be if you lost your job and your health insurance.)

BadgerCare will help keep your family healthy



With Badger Care, you don't have to neglect your own health in order to save money. Your health is vital to your children's well being. Sometimes there are situations that make it difficult for a family to provide health care, such as illness, unexpected bills or car problems. In situations like these, BadgerCare can help you stay healthy and keep your children healthy.

BadgerCare covers both illness and preventive services.

BadgerCare will pay for immunizations for your children, medicine prescribed by a doctor, preventive check-ups, health care services when you are sick — and much more.

Regular preventive check-ups are the best way to catch life-threatening diseases before they become serious.

Check-ups are also a good way to catch routine problems. For example, one woman took her son to have his eyes tested and discovered *she* couldn't read the chart. Mother and child were tested and now both have new glasses.

BadgerCare can protect your family from bills for an unexpected illness or accident.

Some families will need to pay a premium or copayment

You may not have to pay at all, but if you do, the amount you pay depends on your family income.

If your family income is below 150% of the federal poverty level, you will pay no premium or charge. If it's above 150%, you will pay a monthly premium that is no more than 3.5% of your family income.

Those who are on a fee-for-service plan may need to make a copayment. You are exempt from a copayment if your coverage is for children under the age of 18 or if you are enrolled in BadgerCare HMO.

If you think you might be eligible, call today to apply.

CALL: 1-800-362-3002
(TTY and translation services available.)

OR CONTACT:
The county/tribal social or human services department or local W-2 agency in your county.

Find out more at
www.dhfs.state.wi.us